		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040683

Facility Name: Alden Long Grove Rehab & HC Ctr

Address: Box 2308, RFD Old Hicks Rd. (Number) Long Grove (City) 60047 (Zip Code)

County: Lake

Telephone Number: (773) 286-3883 **Fax #** (773) 286-3743

IDPA ID Number: 36-4003486

Date of Initial License for Current Owners: 03/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven M. Kroll

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	248	Skilled (SNF)	248	90,520	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	248	TOTALS	248	90,520	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,450	1,692	3,461	12,603	8
9	SNF/PED					9
10	ICF	39,115	3,006	757	42,878	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,565	4,698	4,218	55,481	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.29%

D. How many bed-hold days during this year were paid by Public Aid?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 3/1/95

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 3/1/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 53 and days of care provided 3,035

Medicare Intermediary Administar Fedral

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	285,923	26,012	6,000	317,935	1,904	319,839		319,839			1
2	Food Purchase		361,865		361,865	(32,066)	329,799	(19,547)	310,252			2
3	Housekeeping	166,415	32,311		198,726	1,834	200,560		200,560			3
4	Laundry	51,235	12,153		63,388	118	63,506		63,506			4
5	Heat and Other Utilities			112,151	112,151		112,151	(4)	112,147			5
6	Maintenance	46,092		136,602	182,694	16,791	199,485	15,168	214,653			6
7	Other (specify):*											7
8	**TOTAL General Services**	549,665	432,341	254,753	1,236,759	(11,419)	1,225,340	(4,383)	1,220,957			8
	B. Health Care and Programs											
9	Medical Director			33,000	33,000		33,000		33,000			9
10	Nursing and Medical Records	2,324,068	139,239	6,448	2,469,755	6,067	2,475,822	(9,421)	2,466,401			10
10a	Therapy	51,635			51,635		51,635		51,635			10a
11	Activities	72,714	244		72,958		72,958		72,958			11
12	Social Services	12,622			12,622		12,622		12,622			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,461,039	139,483	39,448	2,639,970	6,067	2,646,037	(9,421)	2,636,616			16
	C. General Administration											
17	Administrative	147,454			147,454		147,454		147,454			17
18	Directors Fees											18
19	Professional Services			658,371	658,371		658,371	(609,600)	48,771			19
20	Dues, Fees, Subscriptions & Promotions			42,573	42,573	(13,047)	29,526	(16,544)	12,982			20
21	Clerical & General Office Expenses	427,851	14,125	8,843	450,819	13,047	463,866	25,632	489,498			21
22	Employee Benefits & Payroll Taxes			396,993	396,993	21,939	418,932	61,843	480,775			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,259	4,259		4,259	12,126	16,385			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			54,944	54,944		54,944		54,944			26
27	Other (specify):* **Bad debt**			213,331	213,331		213,331	(213,331)				27
28	**TOTAL General Administration**	575,305	14,125	1,379,314	1,968,744	21,939	1,990,683	(739,874)	1,250,809			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,586,009	585,949	1,673,515	5,845,473	16,587	5,862,060	(753,678)	5,108,382			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr #0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation					81,887	81,887	13,146	95,033			30
31	Amortization of Pre-Op. & Org.							1,558	1,558			31
32	Interest			467,333	467,333		467,333	(421,257)	46,076			32
33	Real Estate Taxes			111,943	111,943		111,943	4,258	116,201			33
34	Rent-Facility & Grounds			1,881,307	1,881,307		1,881,307	638	1,881,945			34
35	Rent-Equipment & Vehicles			8,902	8,902		8,902	18,042	26,944			35
36	Other (specify):* Mortg. Insurance			98,474	98,474	(98,474)						36
37	**TOTAL Ownership**			2,567,959	2,567,959	(16,587)	2,551,372	(383,615)	2,167,757			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,731	321,299	470,030		470,030	(115,731)	354,299			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		78		78		78	(78)	(0)			41
42	Provider Participation Fee			135,780	135,780		135,780		135,780			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		148,809	457,079	605,888		605,888	(115,809)	490,079			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,586,009	734,758	4,698,553	9,019,320		9,019,320	(1,253,103)	7,766,217			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(469,787)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,273)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(213,331)	27		24
25	Fund Raising, Advertising and Promotional	(5,561)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (690,002)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(526,519)		34
35	Other- Attach Schedule	(36,582)	pg 5a	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (563,101)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,253,103)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden Long Grove Rehab & HC Ctr

ID# 0040683

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	LEGAL FEES-COLLECTIONS	$ (17,879)	21	1
2	BACK OUT IL. HEALTHCARE ASSOC PAC FEES	(1,104)	20	2
3	BACK OUT MARKETING MGT FEE	(7,223)	20	3
4	BACK OUT MARKETING CONSULTANT	(3,013)	20	4
5	BACK OUT CLOTHING GIFT SHOP	(78)	41	5
6	Record add'l def maint exp to correct amt.	5,998	6	6
7	Adj deprec exp to correct/match detail	(207)	30	7
8	back out Orsini prior yr settlement cost	(9,598)	19	8
9	Back out utility late fee	(3,477)	5	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(36,582)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,273)	0	0	(18,274)	0	0	0	0	0	0	0	(19,547)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,477)	0	3,473	0	0	0	0	0	0	0	0	(4)	5
6	Maintenance	5,998	0	9,251	0	0	0	(81)	0	0	0	0	15,168	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,248	0	12,724	(18,274)	0	0	(81)	0	0	0	0	(4,383)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(9,252)	(169)	0	0	0	0	0	0	(9,421)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(9,252)	(169)	0	0	0	0	0	0	(9,421)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,598)	0	(600,002)	0	0	0	0	0	0	0	0	(609,600)	19
20	Fees, Subscriptions & Promotions	(16,951)	0	407	0	0	0	0	0	0	0	0	(16,544)	20
21	Clerical & General Office Expenses	(17,879)	0	25,296	14,481	3,734	0	0	0	0	0	0	25,632	21
22	Employee Benefits & Payroll Taxes	0	0	61,249	0	594	0	0	0	0	0	0	61,843	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	12,126	0	0	0	0	0	0	0	0	12,126	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(213,331)	0	0	0	0	0	0	0	0	0	0	(213,331)	27
28	**TOTAL General Administration**	(257,759)	0	(500,924)	14,481	4,328	0	0	0	0	0	0	(739,874)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(256,511)	0	(488,200)	(13,045)	4,159	0	(81)	0	0	0	0	(753,678)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(207)	0	12,564	0	789	0	0	0	0	0	0	13,146	30
31	Amortization of Pre-Op. & Org.	0	0	1,518	0	0	40	0	0	0	0	0	1,558	31
32	Interest	(469,787)	0	47,347	0	622	561	0	0	0	0	0	(421,257)	32
33	Real Estate Taxes	0	0	4,065	0	193	0	0	0	0	0	0	4,258	33
34	Rent-Facility & Grounds	0	0	638	0	0	0	0	0	0	0	0	638	34
35	Rent-Equipment & Vehicles	0	0	18,042	0	0	0	0	0	0	0	0	18,042	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(469,994)	0	84,174	0	1,604	601	0	0	0	0	0	(383,615)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(11,346)	(24,807)	(79,578)	0	0	0	0	0	(115,731)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(78)	0	0	0	0	0	0	0	0	0	0	(78)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(78)	0	0	(11,346)	(24,807)	(79,578)	0	0	0	0	0	(115,809)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(726,584)	0	(404,026)	(24,391)	(19,044)	(78,977)	(81)	0	0	0	0	(1,253,103)	45

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	employee benefits	$	Alden Management Services	100.00%	$ 61,249	$ 61,249	15
16	V	19	profess. Fees	611,169	Alden Management Services		11,167	(600,002)	16
17	V	21	g & a		Alden Management Services		25,296	25,296	17
18	V	5	utilities		Alden Management Services		3,473	3,473	18
19	V	6	maintenance		Alden Management Services		9,251	9,251	19
20	V	24	auto/travel		Alden Management Services		12,126	12,126	20
21	V	20	subscriptions/etc		Alden Management Services		407	407	21
22	V	30	depreciation		Alden Management Services		12,564	12,564	22
23	V	31	amortization		Alden Management Services		1,518	1,518	23
24	V	33	real estate tax		Alden Management Services		4,065	4,065	24
25	V	34	rent		Alden Management Services		638	638	25
26	V	35	rent-equip/vehicles		Alden Management Services		18,042	18,042	26
27	V	32	interest		Alden Management Services		47,347	47,347	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 611,169			$ 207,143	$ * (404,026)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube feeding	$ 27,522	Pyramid Health Care Services	100.00%	$ 9,248	$ (18,274)	15
16	V	10	nursing supplies	13,430	Pyramid Health Care Services		4,178	(9,252)	16
17	V	39	per diem/other supplies	27,672	Pyramid Health Care Services		16,326	(11,346)	17
18	V	21	general & admin		Pyramid Health Care Services		14,481	14,481	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 68,624			$ 44,233	$ * (24,391)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	$ 73,693	Forum Extended Care II	100.00%	$ 56,496	$ (17,197)	15
16	V	10	House stock	726	Forum Extended Care II		557	(169)	16
17	V	39	IV	32,608	Forum Extended Care II		24,998	(7,610)	17
18	V	22	Employee benefits		Forum Extended Care II		594	594	18
19	V	21	G & A		Forum Extended Care II		3,734	3,734	19
20	V	32	Interest		Forum Extended Care II		622	622	20
21	V	33	Real estate taxes		Forum Extended Care II		193	193	21
22	V	30	Depreciaton		Forum Extended Care II		789	789	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 107,027			$ 87,983	$ * (19,044)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 314,703	Community Physcial Therapy	100.00%	$ 235,125	$ (79,578)	15
16	V	32	Interest		Community Physcial Therapy		561	561	16
17	V	31	Amortizaton		Community Physcial Therapy		40	40	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 314,703			$ 235,726	$ * (78,977)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance expense	$ 27,093	Alden Bennett Construction	100.00%	$ 27,012	$ (81)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 27,093			$ 27,012	$ * (81)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Floyd Schlossberg a.	President	Chief Executive	100.00	343,798	2.14	5.35	SALARY	$ 19,414	17-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.00	86,810	2.14	5.35	SALARY	4,902	17-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	81,229	2.14	5.35	SALARY	4,587	17-1	3
4											4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10											10
11											11
12											12
13								TOTAL	$ 28,904		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson Ave.
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see page 8A (also on page 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Ams -related Party & t.s. Int	X		Working capital							52,765	6
7	Related party - FECII	X		Working capital							622	7
8	Related party - CPT	X		Working capital							561	8
9	TOTAL Facility Related						$	$			$ 53,948	9
	B. Non-Facility Related*											
10	Offset interest expense with interest income										(7,871)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,871)	14
15	TOTALS (line 9+line14)						$	$			$ 46,076	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr **#** 0040683 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	98,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	103,443	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,443	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	106,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	111,943	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	89,318	8
	1998	90,656	9
	1999	88,811	10
	2000	93,552	11
	2001	103,443	12

Accrual based on 3% increase over prior year bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Long Grove Rehab & HC Ctr COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0040683

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-36-100-002	Nursing home facility	$ 103,442.78	$ 103,442.78
2.		Related Party - Alden Management	$ 76,052.00	$ 4,065.00
3.		Related Party - Forum	$ 8,608.00	$ 193.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 188,102.78	$ 107,700.78

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,632 B. General Construction Type: Exterior brick Frame steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 18,359	$	22	$	$	$ 18,359	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SHELVING			1995	5,122	256	20	256		1,985	9
10	ROOF REPAIR			1995	3,000	300	10	300		2,300	10
11	STEAMER REPAIR			1995	2,686	269	10	269		2,059	11
12	EXIT DOOR-FIRE			1995	4,225	282	15	282		2,089	12
13	REPAIR BOILER/HVAC-MAJ.REP.			1995	4,712		5			4,712	13
14	PIPE/VALVE/THERMOSTAT			1996	1,460	73	20	73		529	14
15	ELECTRICAL REPAIR/INSTALLATION			1996	2,110	106	20	106		730	15
16	SIGN			1996	7,233		5			7,233	16
17	WATER HEATER ON DISHWASHER			1996	7,464	746	10	746		4,976	17
18	WALLGUARD			1996	2,096	140	15	140		908	18
19	INSTALL BOILER-MAJ.REP.			1996	33,750	1,688	20	1,688		10,828	19
20	REPLACE CONDENSOR WALK IN COOLER			1996	5,514	551	10	551		3,538	20
21	INSTALL ALUM. LOGO			1996	1,995	166	12	166		1,205	21
22	DESIGN SERVICE			1996	8,100	405	20	405		2,531	22
23	WASHROOM IMPROVEMENTS			1996	2,186	109	20	109		692	23
24	PIPING-MAJ.REP.			1996	4,000	267	15	267		1,622	24
25	PIPING-MAJ.REP.			1996	3,500	233	15	233		1,458	25
26	ATASH(replaced heat detector&fire dampers)			1997	959	16	5	16		959	26
27	ATASH(installed access panels)			1997	924	15	5	15		924	27
28	ATASH(fire alarm repairs)			1997	2,212	37	5	37		2,212	28
29	CLIMATE(installation of water heaters)			1997	7,342	245	5	245		7,342	29
30	CLIMATE(replced hydro.boiler)			1997	4,568	228	5	228		4,568	30
31	Wally's flooring(install new tiles).			1997	2,659	222	5	222		2,659	31
32	ATASH(SPRINKLER WORK)INV.#9120&9121			1997	3,072	154	5	154		3,072	32
33	ATASH(SPRINKLER WORKS)			1997	2,062		5			2,062	33
34	Climate srvc(two water heater)			1997	15,600	260	5	260		15,600	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Wigdahl(install light fixtures)	1997	$ 7,207	$ 480	5	$ 480	$	$ 7,207	37
38	Wigdahl(install light fixtures)	1997	6,204	620	5	620		6,204	38
39	Climate(install compressor)	1997	6,750	675	5	675		6,750	39
40	Star contractor(door frame)	1997	2,973	347	5	347		2,973	40
41	Wally's flooring(install new tiles).	1997	2,659	133	5	133		2,659	41
42	Climate svcs(new pipe and air vents)	1997	6,354	847	5	847		6,354	42
43	EQUIPMENT INT'L LTD. (labor, parts, assembly)	1997	2,542	424	5	424		2,542	43
44	DOOR	1997	3,109	311	10	311		1,787	44
45	INSTALL NEW DROP CEILING	1997	2,175	181	12	181		1,042	45
46	DESIGN SERVICES	1997	931	47	20	47		275	46
47	NEW DRIVEWAY LIGHTING	1998	8,101	540	15	540		2,655	47
48	REPLACE WASHING MACHINE MOTORS	1998	1,752	350	5	350		1,723	48
49	REPLACE BOILER	1998	4,253	212	20	212		1,043	49
50	REPAIR PUMP MOTOR	1998	3,312	662	5	662		3,257	50
51	REPAIR DRYERS	1998	2,554	253	10	253		1,225	51
52	REPAIR EMEGENCY CIRCUITS	1998	1,510	151	10	151		730	52
53	REPAIR EMEGENCY LIGHTING SYSTEM	1998	273	27	10	27		132	53
54	REPLAC E COMPRESSOR	1998	1,301	130	10	130		629	54
55	REPLACE SEAVES ON ROOF	1998	10,500	700	15	700		3,092	55
56	REPLACE HOT WATER HEATER	1998	2,200	220	10	220		990	56
57	REPAIR GENERATOR	1998	5,228	349	15	349		1,510	57
58	REPLACE BEARING IN WASHER	1998	1,296	65	20	65		286	58
59	PATTEN-REPAIR GENERATOR	1998	655	33	20	33		145	59
60		1998	1,738	116	15	116		483	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 242,487	$ 14,641		$ 14,641	$	$ 162,846	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 242,487	$ 14,641		$ 14,641	$	$ 162,846	1
2	D.B.S. Contracting(sprinkler system installation)	1999	32,838	1,314	25	1,314		5,145	2
3	D.B.S. Contracting(sleeve pipeline for sprinkler system)	1999	5,720	572	10	572		2,240	3
4	Hobart(repair dishwasher)	1999	2,560	256	10	256		960	4
5	Climate Service (pipework for boiler and storage tank)	1999	2,032	406	5	406		1,524	5
6	D.B.S. Contracting (need invoice)	1999	3,425	343	10	343		1,227	6
7	Chicago Cooling (repair pump)	1999	2,482	496	5	496		1,778	7
8	AMC Building Material	1999	4,544	454	10	454		1,628	8
9	AMC Sprinklers	1999	4,238	424	10	424		1,448	9
10	System Electric(generator repair)	1999	2,720	272	10	272		884	10
11	Patten Industries(install starter)	1999	5,495	550	10	550		1,786	11
12	AMC Building Material	1999	2,063	206	10	206		670	12
13	Fox Valley(sprinkler repair)	1999	1,803	120	15	120		381	13
14	Alden Bennet Cons.install tank)	1999	6,201	628	10	628		1,936	14
15	Alden Bennet Cons.(repair wind damage)	1999	33,802	1,368	25	1,368		4,217	15
16	AMC Security system	1999	7,273	727	10	727		2,242	16
17	AMC carpentry	1999	9,435	943	10	943		2,909	17
18	Climate Service (repair HVAC)	1999	9,358	936	10	936		2,886	18
19	ABC-construction mainten. Adjustment-various	1999	6,129	409	10	409		1,362	19
20	Climate services (A/C REPAIR)	2000	2,482	496	5	496		1,489	20
21	US foodservice (Steam table for fine dining room)	2000	9,816	654	15	654		1,909	21
22	B&L Locksmith (knob set)	2000	3,750	250	15	250		708	22
23	Alden Bennett Construction (major repairs)	2000	1,791	358	5	358		896	23
24	D.B.S. Contracting (repair lawn sprikler system)	2000	1,635	327	5	327		818	24
25	D.B.S. Contracting (repair lawn sprikler system)	2000	2,285	457	5	457		1,143	25
26	Alden Bennett Construction (major repairs)	2000	2,907	291	10	291		678	26
27	Alden Bennett Construction (time & material billing per fac)	2000	2,315	231	10	231		482	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 411,584	$ 28,130		$ 28,130	$	$ 206,194	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 411,584	$ 28,130		$ 28,130	$	$ 206,194	1
2	alden design-architectural/designing	2000	2,628	131	20	131		318	2
3	alden design-architectural/designing	2000	3,300	165	20	165		399	3
4	ABC-time & materials-maj. Leasehold improv-various	2000	2,110	141	15	141		328	4
5	West side electric079020(wattmiser)	2001	1,362	136	10	136		272	5
6	Patten industries 1137844(major repair for electric starting motor)	2001	4,103	410	10	410		821	6
7	Alden bennett construction (drive way improvement)	2001	1,206	80	15	80		114	7
8	T & T irrigation (lawn sprinkler system)	2001	2,064	206	10	206		258	8
9	Alden bennett construction	2001	10,659	1,066	10	1,066		1,954	9
10	New horizons commu1884(installation hardware phone)	2001	1,986	199	10	199		381	10
11	ABC-Pond, parking lot, and site improvements related to these	2001	692,957	27,718	25	27,718		55,437	11
12	Alden Bennett Constr.-Roof repairs	2002	2,041	238	5	238		238	12
13	CSI-Coker	2002	2,502	459	5	459		459	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,138,503	$ 59,080		$ 59,080	$	$ 267,171	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,138,503	$ 59,080		$ 59,080	$	$ 267,171	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	19,335		20			19,334	4
5	Leasehold Improvement-Remodeling	1980	1,208		10			1,208	5
6	Leasehold Improvement-Remodeling	1986	645		5			645	6
7	Leasehold Improvement-Remodeling	1990	404		5			404	7
8	Leasehold Improvement-Remodeling	1991	94		5			94	8
9	Leasehold Improvement-Remodeling	1993	8,304	830	10	830		8,304	9
10	Leasehold Improvement-Remodeling	1993	6,504	469	9.7	469		6,504	10
11	Leasehold Improvement-sign	1994	261	22	12	22		174	11
12	Leasehold Improvement-dryvit	1995	443	44	10	44		310	12
13	Leasehold Improvement-new ac	1999	723	48	15	48		145	13
14	Leasehold Improvement-roof	1985	972	52	19	52		922	14
15	Leasehold Improvement-roof	1994	863	58	15	58		518	15
16	Leasehold Improvement-roof	1997	819	55	15	55		328	16
17	Leasehold Improvement-roof	1998	1,390	93	15	93		464	17
18	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11		33	18
19	Leasehold Improvement-hallway lighting	2001	155	16	10	16		32	19
20	Leasehold Improvement-DAI	2001	195	19	10	19		38	20
21	Leasehold Improvement-bathrooms	2002	687	69	10	69		69	21
22	Leasehold Improvement-Remodeling	2002	98	20	5	20		20	22
23	Related Party-AMS:								23
24	Leasehold Improvement-Remodeling	1993	4,266		7			4,266	24
25	Leasehold Improvement-Remodeling	1994	2,112		7			2,112	25
26	Leasehold Improvement-Remodeling	2002	5,221		7				26
27									27
28									28
29									29
30									30
31									31
32	Related Party-Forum Ext. Care	1999	1,764	142	40	142		183	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,195,077	$ 61,028		$ 61,028	$	$ 313,278	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 254,286	$ 27,403	$ 27,403	$	VARIOUS	$ 138,800	71
72	Current Year Purchases	30,713	2,179	2,179		VARIOUS	2,179	72
73	Fully Depreciated Assets	42,647	631	631		VARIOUS	9,796	73
74								74
75	TOTALS	$ 327,646	$ 30,213	$ 30,213	$		$ 150,775	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	CAR ENGINE/BUS/VAN	: DODGE	98-'02	$ 12,336	$ 3,792	$ 3,792	$	3	$ 9,992	76
77										77
78										78
79										79
80	TOTALS			$ 12,336	$ 3,792	$ 3,792	$		$ 9,992	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,535,059	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 95,033	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 95,033	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 474,046	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$ n/a	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ n/a	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: TL Enterprises
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [x] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [x] YES [ ] NO Terms: purchase option/deposit *

10. Effective dates of current rental agreement:
    Beginning 3/1/95
    Ending 3/1/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ 1,881,301
13.	/2004	$ 1,881,301
14.	/2005	$ 1,881,301

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 8,901 Description: copy machine lease
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	non-patient transport		$ 157.50	$ 1,890	17
18	reated patrty			18,042	18
19					19
20					20
21	TOTAL		$ 157.50	$ 19,932	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled nurses on site

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 125,866	$		$ 125,866	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			38,444			38,444	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			148,215			148,215	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see page 16a	# of prescrpts			52,519			52,519	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see page 16a				(10,745)			(10,745)	13
14	TOTAL			$		$ 354,299	$		$ 354,299	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr **#** 0040683 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 244,504)	1,285,344		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,899		6
7	Other Prepaid Expenses	4,774		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Tax/ins.escrows/Due to TL enter	54,967		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,362,984	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,290,504		15
16	Equipment, at Historical Cost	235,082		16
17	Accumulated Depreciation (book methods)	(497,364)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Purchase option on Facility	744,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,772,222	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,135,206	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 611,124	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,008		28
29	Short-Term Notes Payable	45,617		29
30	Accrued Salaries Payable	265,448		30
31	Accrued Taxes Payable (excluding real estate taxes)	38,736		31
32	Accrued Real Estate Taxes(Sch.IX-B)	106,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued exp/ due to idpa	323,447		36
37	Due to affiliates/ Due to BBS	4,759,726		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,201,606	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	119,579		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred rent	865,453		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 985,032	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,186,638	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,051,432)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,135,206	$	48

***(See instructions.)**

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,177,398)	1
2	Restatements (describe):		2
3	**External audit adjustments made after 2001 cost report**		3
4	**was submitted. These have not effect on prior years report:**		4
5	**Bad debt, medicare revenues (non-allowables)**	1,391,070	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,786,328)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,265,104)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,265,104)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,051,432)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,223,952	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,223,952	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	48,661	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 48,661	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RECOVERY OF BAD DEBT	12,702	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,702	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,285,315	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,236,759	31
32	Health Care	2,639,970	32
33	General Administration	1,968,744	33
	B. Capital Expense		
34	Ownership	2,567,959	34
	C. Ancillary Expense		
35	Special Cost Centers	470,108	35
36	Provider Participation Fee	135,780	36
	D. Other Expenses (specify):		
37	Related party salary allocations	(468,901)	37
38	transactions not included on this page, but included		38
39	on page 3&4.		39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,550,419	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,265,104)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,265,104)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not yet done **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,962	2,331	$ 69,808	$ 29.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	27,283	30,530	810,734	26.56	3
4	Licensed Practical Nurses	15,490	16,260	400,882	24.65	4
5	Nurse Aides & Orderlies	75,497	79,409	956,216	12.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,997	2,106	24,498	11.63	9
10	Activity Assistants	4,037	4,277	49,247	11.51	10
11	Social Service Workers	696	784	12,380	15.79	11
12	Dietician					12
13	Food Service Supervisor	1,250	1,418	31,834	22.45	13
14	Head Cook	4,783	5,041	53,794	10.67	14
15	Cook Helpers/Assistants	24,953	26,482	199,977	7.55	15
16	Dishwashers					16
17	Maintenance Workers	2,024	2,080	25,199	12.11	17
18	Housekeepers	21,980	23,073	174,850	7.58	18
19	Laundry	5,960	6,165	47,438	7.69	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	5,370	5,736	111,322	19.41	22
23	Office Manager					23
24	Clerical	3,235	3,307	33,317	10.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,816	1,948	50,372	25.86	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Clinical SS	1,088	1,104	28,696	25.99	32
33	Other(specify) ALZHEIMERS	3,656	3,826	36,544	9.55	33
34	TOTAL (lines 1 - 33)	203,077	215,877	$ 3,117,108 *	$ 14.44	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,000	1-3	35
36	Medical Director	Monthly	33,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,448	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 45,448		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Malenock, E	Administrator	0	65,144
Executive/Management	Administrator	0	82,310
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 147,454

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management Services	MNGT. FEES	$ 611,169
BDO	ACCT. FEES	11,002
Ken Fisch/Greenburg/Hermann	Legal Fees	21,299
Medicom	Software consultant	415
Talx Corp	Work comp consulting	220
Barry Greenburg	Legal consultations	2,245
US Gas & Energy	Utilities	2,232
Orsini Nursing Agency	nursing agency fee *	9,598
Various	Misc.	191
* prior yr settlement cost- backed out on pg 5a		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 658,371

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,059
Unemployment Compensation Insurance	30,757
FICA Taxes	224,430
Employee Health Insurance	51,278
Employee Meals	32,066
Illinois Municipal Retirement Fund (IMRF)*	
Related party - FECII	594
dental, life, pension costs	105
relations,miscell, & backround chks	246
drug test, 401k match, vaccinations	2,990
related party-Ams	61,249
TOTAL (agree to Schedule V, line 22, col.8)	$ 480,775

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Surety bond fees, dues & subcriptions	760
IL Health Care Assoc	11,704
Employee Assoc. Due	111
related party-Ams	407
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,982

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
misc/gas/repairs	3,089
related party-Ams	12,126
Seminar Expense	
Comprehensive Therapeutic	500
O.C.C./Life Serv. Network	380
Other	290
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,385

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PLUMBING	9/95	$ 2,766	3	$ 0	$	$	$	$	$	$	$	$
2	PAINTING,SMOKE DET	12/95	3,737	3-10	128	128	128	128	128	128	128	128	128
3	PAINTING	1/96	2,369	3	0								
4	PAINTING	2/96	1,798	3	97	0							
5	PAINTING	3/96	1,844	3	102	0							
6	PAINTING	5/96	2,336	3	259	0		see page 22A for grand totals….					
7	PAINTING	4/96	12,094	3	1,008	0							
8	BOILER REPAIRS	5/96	2,100	3	233	0							
9	PAINTING	7/96	4,364	3	727	0							
10	PAINTING	6/96	2,141	3	297	0							
11	PAINTING	8/96	4,395	3	855	0							
12	PAINTING	9/96	1,606	3	358	0							
13	CHEMICAL FILTER	11/96	2,229	15	149	149	149	149	149	149	149	149	149
14	PAINTING	12/96	2,331	3	712	0							
15	Install compressor(hvac)	6/97	4,125	3	1,375	573	0						
16	painting	6/97	35,000	3	11,667	4,861	0						
17	hvac/hot water sensor	6/97	2,322	3	774	323	0						
18	water chiller/hvac	7/97	1,800	3	600	300	0						
19	boiler controller/hvac	11/97	3,125	3	1,042	868	0						
20	TOTALS		$ 92,482		$ 20,382	$ 7,202	$ 277	$ 277	$ 277	$ 277	$ 277	$ 277	$ 277

Facility Name & ID Number Alden Nursing Center - Long Grove Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	**Month & Year Improvement Was Made**	**Total Cost**	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Climate Srv-repair pump	12/97	1,859	3	620	568	0						
2	Custom Appl-a/c's	1/98	2,940	3	980	980	0						
3	painting 1998	3/98	4,139	3	1,380	1,380	230	0					
4	painting 1998	6/98	5,582	3	1,861	1,861	776	0					
5	painting 1998	9/98	4,240	3	1,413	1,413	942	0					
6	painting 1998	12/98	3,014	3	1,005	1,005	921	0					
7	H.Scales-abt appliance	8/99	3,034	3	421	1,011	1,011	590					
8	CSI-flow switch/hvac	10/99	3,828	3	319	1,276	1,276	957	0				
9	Capps-sewer rodding	9/99	1,680	3	187	560	560	373	0				
10	CSI- hvac	12/99	2,482	3	69	827	827	758	0				
11	Painting>$1,500 ytd 1999	7/99	13,288	3	2,215	4,429	4,429	2,215	0				
12	CAPPS PLUMBING (SEWAGE CLE	5/00	5,430	3		1,207	1,810	1,810	603	0			
13	VENDOR REC REVERSING		(2,482)	3									
14	GT MECHANICAL (chiller circulatin	8/00	1,523	3		212	508	508	295	0			
15	WRITE OFF CUST MAPP ?		(2,940)	3									
16	Alde Bennett Construction (time & m	12/00	21,314	3		592	7,105	7,105	6,512	0			
17	Painting>$1,500 ytd 2000	7/00	8,699	3		1,450	2,900	2,900	1,450	0			
18	GT Mechan. (hvac repair)	2001	1,507	3			0	502	502	503	0		
19	Painting>$1,500 for 2001	2001	2,048	3			341	683	683	341	0		
20	Sherwin Williams --Painting	1/02	9,990	3				3,330	3,330	3,330			
21	CSI -- Service Cleveland	2/02	6,313	3				579	2,104	2,104	1,526		
22	Totals from Page 22 . . .		92,482		20,382	7,202	277	277	277	277	277	277	277
23	TOTALS		$ 189,969		30,852	25,972	23,913	22,586	15,756	6,555	1,803	277	277

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **IL Healthcare Assoc. $11,704**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,380** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ _____
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **32,066** Has any meal income been offset against related costs? **yes** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **n/a**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **BDO Seidman, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.